

# **Utah Public Mental Health System Information & Outcome Systems' Report FY 2000**

## **Executive Summary**

**State of Utah  
Utah Department of Human Services  
Division of Mental Health  
\*Center for Program Evaluation and Research (CPEAR)**

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## Preface

The introduction and executive summary are part of the annual Information and Outcome Systems' report for FY 2000. Approximately 100 pages in length, the report included tables, graphs and text. Although it is currently out of print, the longer report is expected to be placed on the Web in the near future as will the FY 2001 report and executive summary when published.

An error was recently discovered in the report in our broad classification of major depression and major mental illness. This error affected Tables 15a, 15b, 16, 17c, and Figure 7. Other mood disorders, primarily *dysthymia* and *cyclothymia*, had inadvertently been included in the major depression and major mental illness categories. Corrections have been made in the executive summary and report.

## Acknowledgements

We appreciate the support and assistance received from the listed persons below, particularly our colleagues "in the trenches" who collected and submitted data, and to all who reviewed data tables prior to our analysis and reporting. A special thanks is expressed to Kay Wallis and Jayne Norton for their very helpful assistance.

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UBHN	John Tanner, Exec. Director Harold Morrill, Chair James Whear	State Hospital	Mark Payne, Superintendent Isaac Thomas August Lehman
Bear River	Mick Pattinson, Director Beth Smith	Central Utah	Kathy Hobby, Director Steve Brown Eddie Jean Coates Pam Baxter
Weber	Harold Morrill, Director Ron King Stacey Boydston	Southwest	Paul Thorpe, Director Karen Anderson Sherry Floyd Michael Deal
Davis	Maureen Womack, Director Todd Souter Richard Langford	Northeastern	Ron Perry, Director Gary Clark
Valley	David Dangerfield, Director Catherine Carter Dave Justice Steve Taylor	Four Corners	Robert Greenberg, Director Roy Byrd
Wasatch	LeMar Eyre, Director Tom Wallace Julie Westwood	San Juan	Dan Rogers, Director Robert Johnson Joni Lyman

# **Introduction**

## **Purpose and Uses**

This report is produced to enhance decision making by public mental health stakeholders. These stakeholders include consumers, family members of consumers, advocates, the State Board of Mental Health, Department of Human Services, Division of Mental Health (DMH), State Hospital, Division of Health Care Financing, Division of Substance Abuse, local authorities and Community Mental Health Centers (CMHCs), and Utah Behavioral Healthcare Network (UBHN).

All stakeholders would be expected to have an interest in the domains of accessibility, quality/appropriateness, out-comes, consumer satisfaction, and overall service expenditures. Consumers and family members may be interested in knowing how their own CMHC is doing in these domains compared with other CMHCs. The State Board's interest is to examine data from the standpoint of policy, existing and needed.

The DMH is a primary stakeholder in its use of data for administration, planning, continuous quality improvement or CQI, oversight, monitoring, program evaluation, data quality improvement, research, and program areas such as children and youth, cultural competence, housing and case management, consumer management, and aging. To illustrate just two DMH uses, Federal Block Grant reporting for the State mental health plan requires data and indicators, much of which is contained in this report, to assure continued funding. Quantitative data are also used in close connection with the clinical care quality monitoring team to draw samples, suggest data-based areas of focus, and to elaborate on data patterns or hypotheses developed by the clinical quality team while on site visits. The Department of Human Services uses certain aggregated system results for its outcome report to the Governor, the Legislature, and other stakeholders at the Department level.

Individual CMHCs and local authorities may use the data to see how they compare with other centers on target population characteristics, service provision, access, quality/appropriateness, outcomes, and consumer satisfaction. Differences between centers may suggest areas for further evaluation by individual centers for CQI purposes. UBHN may extract information on the public mental health system for use in legislative presentations to the Health and Human Services Appropriations committee. Medicaid may use the data as an independent assessment of outcomes and consumer satisfaction of CMHC consumers who perceive that Medicaid will be the primary funding source for their services.

## **Why comparisons?**

The analysis approach used here is to compare CMHCs, an approach being used in many states. However, this approach does have some limitations. Inherent to this normative approach is that some centers will be higher and others lower than the State average, although not all differences will be statistically significant. Standards are lacking in a normative analysis by which centers may be compared. For example, it is possible that the center with a low value, assuming that low is undesirable, in a state with a high functioning delivery system is both *above* a hypothetical objective stand-ard, and is *higher* than the average that may be observed in other state public mental health systems. The Utah public mental health system should seek such a standard. In spite of the absence of

certain performance or other normative standards, *the practice of comparing centers is fruitful and provides a point of reference for discussing standards in the near future.*

A second benefit of comparisons is that information in the report is potentially heuristic. That is, comparisons may be expected to generate questions about each center's service utilization patterns, consumer characteristics, consumer satisfaction, and treatment outcomes. This in turn may result in further data analysis by a center, and hopefully improvements in service access, quality, effectiveness, and efficiency.

A third benefit of a comparative analysis is the assessment of compliance with Board policy on the continuum of required mental health services. On the other hand, results may suggest changes in policy to better reflect the reality of service provision, especially in rural areas.

A fourth benefit of a comparative approach is the self-correcting process of improving data quality and completeness. It is not uncommon for providers to discover that certain results do not match their objective or subjective experience. Upon further examination, certain data errors may be discovered and overall data quality and completeness improved. When presented as statewide aggregate data, improvement in data quality and completeness is far less likely to occur because of the absence of a point of reference.

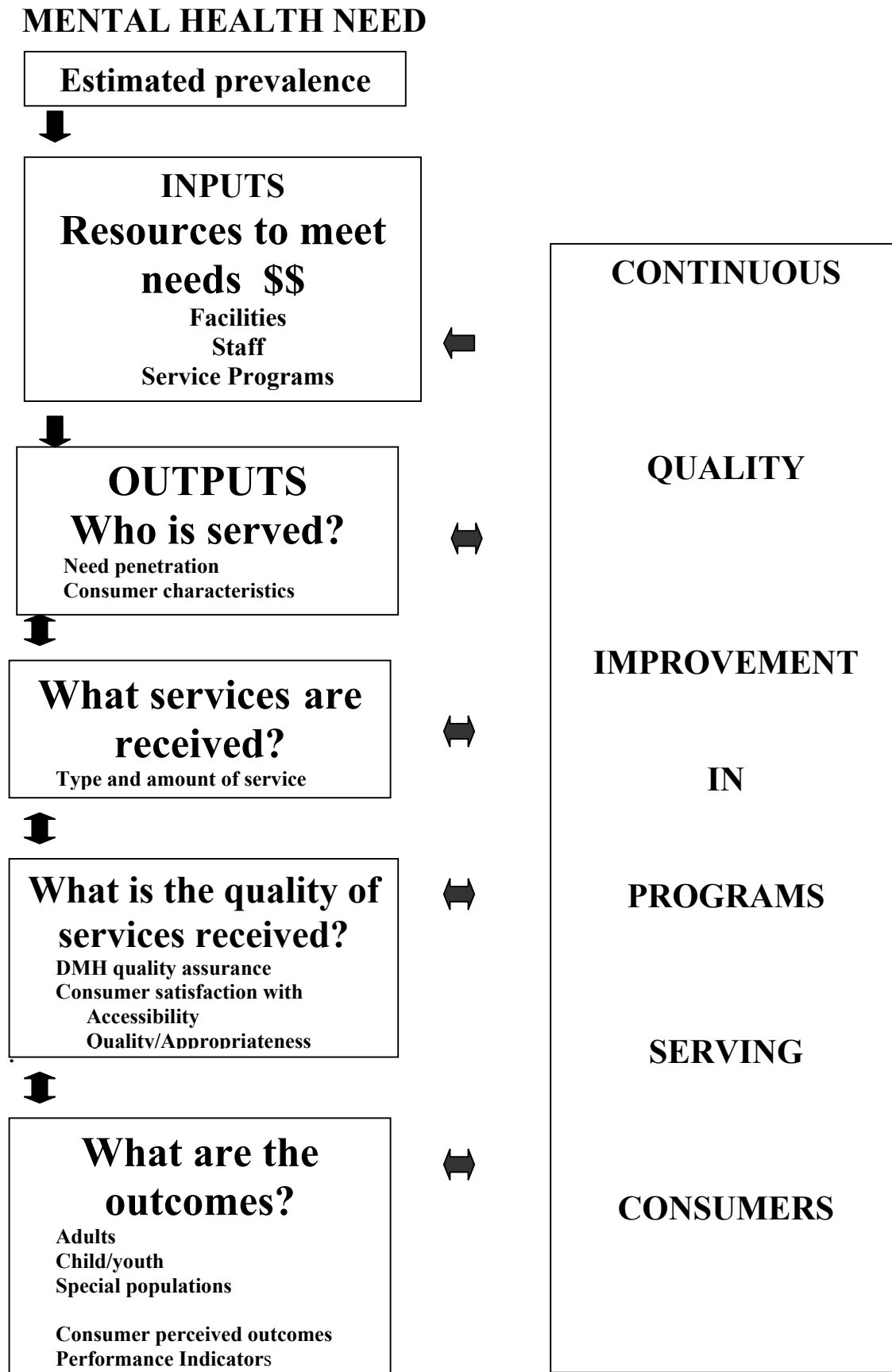
### **Division of Mental Health and CPEAR Philosophy of Decision Support: Description of the Data Decision Model (Figure 1)**

Most of the concepts explicit or implicit to the model are taken from social systems theory. Three macro social systems are pertinent to our discussion: the Federal Government, the State Government, and Utah Community Mental Health Centers (CMHCs). All three are **complex adaptive systems**<sup>1</sup> that have **tensions**<sup>2</sup>, which are collectively viewed as **needs** or social problems. Initially, it was the U.S. Congress that statutorily responded to the need for CMHCs with the Community Mental Health Services Act of 1963. Undoubtedly, a strong advocacy effort preceded the legislation. Later, legislators, advocates, policy makers, and the general public within states concurred with this need and states applied for federal funds to establish CMHCs. Although prevalence surveys<sup>3</sup> are logically first in the model, in reality, they came much later and acted to confirm rather than establish the need.

**Inputs and outputs**<sup>4</sup> are terms borrowed primarily from economics. **Inputs** or resources involve facilities, staff, and a defined set of services requiring funding. Many of the required services are defined in State statutes and Board policies. **Outputs** include statistical data about who is served, what services are received, quality of services, consumer satisfaction and the outcome of services. The two-way arrows define the interrelationship that exists between the output boxes. For example, consumer characteristics may be linked to services, consumer satisfaction, and outcomes.

Two-way arrows are also linked to the goal of data and information—continuous quality improvement (CQI) (see large rectangular box). Similar to NCQA and HEDIS<sup>5</sup>, the Division monitors local CQI efforts and standardized performance measurement, respectively. Arrows that connect the output boxes to CQI are based on social systems concepts of **process and change**<sup>6</sup>, **open systems**<sup>7</sup>, **feedback**<sup>8</sup>, and **goal-directedness**.<sup>9</sup> The model does not imply that State-analyzed data are the *only* outputs or information used in CMHC decision making. Quite the contrary, decisions are made at the CMHC level on the basis of many outputs such as quantitative data, values, leadership experience, discipline values, local authority input, needs, and funding. The model represents an ideal that explicitly links local CQI with the types of data in the output boxes shown in the graph. The model

**Figure 1. A MODEL FOR INTEGRATING DATA AND QUALITY IMPROVEMENT**



output boxes are intended to be one of several potentially important stimuli for change at the local level. In an ideal system, all things equal, changes would be made if data feedback suggest that deviations have occurred from important State and local goals.<sup>9</sup> The model may also be applied to local programs independent of the State.

Two-way arrows connecting output boxes and the CQI box are important to the change process. Very often, data raise additional questions. The integrated UPMHS Information System and Outcome Systems permit very detailed analyses in response to follow-up questions by CMHCs to provide further clarification or elaboration. Theoretically, the integrated information system alone can perform over 1,000 two way cross-tabulations (36 X 32 variables). CPEAR has responded to 48 requests for data in the last six months. When such ad hoc requests for data come from CMHCs on a regular basis, it is anticipated that CQI will be greatly enhanced. The top one-way arrow from the CQI box to the Input box suggests one of the higher level hypothetical changes that can be made in CMHC inputs, that of modifying staff or service programs based on data received from the system and reported by the State.

Some **examples** are given to show how the model may be used. Let us say that Center A's penetration rate is smaller than other CMHCs. It requests an ad hoc report from CPEAR to see how Center A compares with other centers in the type and amount of service provided. Hypothetical results may show that although Center A serves fewer people, it provides proportionally more services to those it serves than each of the other centers. Further analysis may also reveal that Center A serves a larger proportion of SPMI adults and SED children than other centers, and has more favorable consumer satisfaction and outcome results. Data analysis is seldom so simple, but this illustrates the importance of follow up questions.

***The Division's philosophy of statewide data decision support is continuous quality improvement, to promote service program quality for consumers.***

## Footnotes

\*The concept and theory of social systems have survived over the decades.

<sup>1</sup>Walter Buckley, *Sociology and Modern Systems Theory*, Englewood Cliffs, New Jersey: Prentice-Hall, 1967, P. 18. "... sociocultural systems are inherently structure- elaborating and changing."

<sup>2</sup>Herbert A. Thelen in Leonard D. White, *The State of the Social Sciences*, Chicago: University of Chicago Press, 1956. Pp. 184-86.

<sup>3</sup>Epidemiological Catchment Area surveys, *Archives of General Psychiatry*, October 1984 (entire issue), American Medical Association; National Comorbidity Survey, *Archives of General Psychiatry*, American Medical Association, 1994.

<sup>4</sup>The University of Utah Marriott Library currently has 125 books on economic inputs and outputs that were published in the past decade.

<sup>5</sup>The web page for the National Committee on Quality Assurance (NCQA) identifies these purposes of the Committee and the Health Plan Employer Data Information Set (HEDIS).

<sup>6</sup>Buckley, P. 18. For some sociologists, the terms process and change are synonymous.

<sup>7</sup>Buckley, P. 50. The term open system is essential to an organization's viability, continuity, and ability to change.

<sup>8</sup>Buckley, P. 52. Operationally-defined feedback is a basic principle of social systems.

<sup>9</sup>Buckley, P. 53. It is the "deviations [identified by feedback] from the goal-state itself that direct the behavior of the system."

## Executive Summary

### I. Services Profile

The Utah public mental health system consists of ten community mental health centers (CMHCs) and the Utah State Hospital (USH). Four centers, Weber (WB), Davis (DV), Valley (VL), and Wasatch (WS) are in the Wasatch Front (WF) region, and six centers, Bear River (BR), Central Utah (CU), Southwest (SW), Northeastern (NE), Four Corners (FC), and San Juan (SJ) are in the non-Wasatch Front (NWF) region. Data throughout the executive summary will frequently use the above abbreviations.

This section looks at accessibility using three concepts—person accessibility, funding availability (expenditures or resource accessibility), and service accessibility. We also describe the *within-center* allocation of the major services on the CMHC continuum. The method used to compare *service accessibility* among the centers and regions consists of two steps. The first step is computing percents for each center and region based on either the statewide served client population or the statewide SPMI/SED client population. The second step is computing percents for major services for each CMHC based on the statewide total for those services.

**Person accessibility** or penetration rate is based on the number of persons receiving at least one center service as a per-cent of the U.S. Census population in each CMHC geographic area. Non-Wasatch Front centers had much higher person accessibility than WF centers. There is much variance between CMHCs, ranging from 1.48 percent to 5.60 percent. A partial explanation for this large difference might be the generally lower population-to-staff ratios in rural areas, thus permitting staff to serve proportionately more people.

**Funding availability (expenditures or resource accessibility).** Total CMHC expenditures were over \$110 million. Annual cost per person served was highest at VL (\$3,506) and lowest at SJ (\$929). Each center's percent of the state population was calculated and compared with its expenditure as a percent of statewide expenditures. The highest proportional expenditures were in the urban region, largely because of VL, which, although it had about 40 percent of the state's population, expended 52 percent of total CMHC dollars. Expenditures are reflective of the type and amount of services provided (service accessibility). The more intensive and costly services of residential support, residential treatment, and community inpatient or hospitalization were disproportionately pro-vided by WF centers.

**Service allocation (within centers).** This measure is based on *persons* and compares percents with severe mental illness (SPMI/SED) in each center with the allocation percents within each center for *clinic services, day treatment, residential support, residential treatment, and community in-patient*. CMHCs in the WF region had the highest percent of persons with SPMI/SED (48.00%, 35.60%). Valley contributed most to this difference both because of its size and its high SPMI/SED client population (58%). CMHCs as a whole allocated their services to *persons* in the following proportions: Clinic services (76.32%), day treatment (13.59%), residential support (1.07%), residential treatment (3.42%), and community inpatient (6.51%).

Comparing urban and rural regions, *clinic hours* were allocated at a much higher proportion in the NWF region (83.58%, 74.38%). Wasatch and NWF regions allocated *day treatment* to persons at about the same proportion. Primarily the WF region (VL, WS) provided the small amount of *residential support* in the system. Four NWF centers did not provide any residential support. *Residential treatment* was also pre-dominantly a WF service (DV, VL). Davis, a center with only one-third of its consumers rated as having SPMI/SED, matched or exceeded Valley and Wasatch in the large percent of its consumers that received the intensive services of *day treatment* and *residential treatment*. The WF region served many more persons, relatively speaking, in community *inpatient* treatment (WS, VL), the most expensive service on the CMHC continuum. Bear River, FC, and CU also served fair proportions in community inpatient in the NWF region.

**Service accessibility.** When intensive service percents are compared with the SPMI/SED percents (both based on state totals), we have a measure of what we refer to as service accessibility. (A client theoretically has access to services that a CMHC is able to provide). The question is: Do SPMI/ SED persons in the various geographic service areas have equal access to the more intensive services of *day treatment*, *residential support*, *residential treatment*, and *community inpatient or hospitalization*?

Wasatch Front centers, especially VL and DV, had the highest service accessibility ratings. We believe that the WF finding is partly due to the greater cost efficiency of delivering the intensive services of residential and inpatient in areas where population concentrations are greater and where hospital facilities are more accessible. Southwest had a moderately high service accessibility rating.

*Clinic accessibility to persons* was much higher in the rural region. However, although more persons in the NWF area received clinic services, the WF region averaged 19 *contacts* per clinic person served compared to 14 in the NWF region. Average *hours* per clinic person served for the two regions were the same (16). *Day treatment accessibility to persons* was higher in the NWF region. However, service accessibility (*hours* and *contacts*) was higher in the WF region. All CMHCs provided significant person and/or service accessibility to their day treatment clients.

Data variability in this report suggests that *a special study of day treatment programs and outcomes would be useful to determine if more recipient persons, hours, and contacts are associated with enhanced effectiveness.*

*Residential support accessibility* occurred almost exclusively in the WF region (96% of total bed days). Four centers in the NWF front area did not provide any residential support. Persons in residential support stayed for several months, *WF* (avg. 331 days), *NWF* (133 days) *Residential treatment accessibility* was highest in the WF region (87% of total bed days). Residential treatment had much shorter average day numbers (*NWF* 76 days, *WF* 57 days) than residential support.

Board policy specifies that each CMHC must either arrange for or directly provide residential services (support and/or treatment). It may be argued that it is not cost efficient to provide residential services in small rural areas, nor convenient to re-move clients from their own community to receive these services. If this is true, *the Board might consider amending policy to allow housing/in-home skills or some other alternative to meet the residential need for consumers in small geographic areas where demand is too small for the required staffing.*



*Community inpatient accessibility* was greatest on the Wasatch Front where 92 percent of both persons served and bed days were provided. Wide differences existed in CMHC average inpatient days per person. Data ranged from 2.6 days at Wasatch to 16.3 days at Weber. In spite of individual center differences, the WF and NWF regions and the CMHC total were very close in average days per person (7.8).

*Utah State Hospital* provides many services that are similar to the CMHCs (e.g., individual, group, medication therapy, crisis, assessment and testing, case management) plus other services such as physical therapy, dental care and general medical care. However, the unit of service is a bed day, and no attempt has yet been made by the DMH to collect data at a more detailed level for the USH, inpatient, or residential services. The *Hospital* is usually not analyzed in the context of accessibility. The State Hospital served 702 unduplicated persons for a total of 111,634 bed days. Average annual inpatient days per person, including readmissions, was 164.4 or approximately 5 ½ months. This calculation is different from the one usually employed by hospitals. Hospitals, including the USH, primarily use median length of stay. The latter is calculated using discharges and episodes of care. The median length of stay per discharge for the USH was 133 days or nearly 4 ½ months. The average daily census for the USH was 305.6 or a daily occupancy rate of 80%.

**Clinic services.** The average number of sessions and session length are summarized for all persons that received these services in FY 2000: Individual, family, and other 8.8 sessions, 54 minutes; Group therapy 14.1 sessions, 102 minutes; Medication management 8.5 sessions, 22 minutes; Crisis service 2.7, 49 minutes; Intake, assessment/ evaluation, and testing 1.9 sessions, 72 minutes; and case management 9.5 sessions, 38 minutes. Some interesting differences between regions and CMHCs may be found in the annual report.

## **II. Client Profile**

Client profile addresses the question, “whom do we serve?” – age, gender, race, ethnicity, diagnosis, severity of mental illness, employment status, marital status, residential living arrangement, referral source, and expected primary payment source. Featured in this section are the unduplicated number served, and the number of persons in FY 2000 that received at least one service. Readmissions within the same year are ignored, as are multiple visits or services. The query, “whom do we serve?” is logically the first question asked by stakeholders.

*Beginning January 1, 2002, the public mental health system will report Axis I and Axis II multiple diagnoses, and clinicians will update diagnoses not only at admission but also at the six-month case evaluation for each client. The same six-month update by clinicians will be made for severity of mental illness (SPMI and SED). These changes will help to make diagnosis and severity ratings more meaningful and valid for comparative purposes. In addition, employment, and residential living arrangement will be updated at the six-month evaluation, thus enabling the reporting of these two global indicators of outcome.*

**Age.** Using four age groupings, the largest percents of *children/youth* (0-17) served were at NE and WS centers and the lowest percent was at DV, a difference of nearly 20 percent. Davis, however, served the largest percent of *young adults* (18-30). San Juan had the highest percent of persons in the *older* age group (46 and over). Prevalence of mental illness is about the same for the major age groups of children/youth, adults, and older adults (19.8%-22%). However, in spite of similar prevalence to other age groups, only 6.8 percent of persons 54 and

older were served by Utah CMHCs compared to 16.1 percent in the state population in the same age groups. This clearly indicates that older persons were *underserved*, a problem that is not unique to Utah.

Although underserving the older population is a national problem, the system could better serve this population by addressing *barriers* identified in the Surgeon General's report of 1999.

*Barriers* preventing older persons from receiving mental health services are:

- misattribution of symptoms to "normal aging";
- provider uncertainty about diagnosis and optimal treatment;
- reluctance of providers to stigmatize clients;
- physical symptoms distract patients and providers from the underlying illness;
- societal stereotypes confuse mental illness with normal aging, and stigma [applies to all ages] (Pp. 348-349).

For all ages, barriers additionally include:

- "Bewilderment" resulting from the "maze of paths into treatment," and fear of coercive or involuntary treatment. (P. 457).

Another barrier not listed in the Surgeon General's report is:

- Lack of, or inadequate, transportation to treatment facilities.

**Gender.** Statewide, 57.6 percent of *adults* served by CMHCs were *female*, whereas only 37.6 percent of State Hospital adults were female. For *children and youth*, 41.1 percent of CMHC clients and 37.8 per-cent of State Hospital patients were female.

**Race.** The *white* service population, including Hispanic, was 91.7 percent for adults and 86.7 percent for children and youth. Over half (52.3%) of San Juan adults were *American Indians*. For children and youth, American Indians accounted for 38.5 percent at San Juan.

**Ethnicity.** Statewide, 6.2 percent of adults and 8.8 percent of children and youth were of *Hispanic* origin, primarily in the WF region.

**Diagnosis (adults).** *Substance abuse* was the predominant diagnosis at CU and DV. Other centers with fairly large proportions of substance abuse consumers were SW, FC, SJ, WB, and VL. Each of these centers is the identified substance abuse provider in its respective service area. When substance abuse is excluded from the computation, *major depression* was by far the most common diagnostic category for CMHCs, followed by *schizophrenia*, *bi-polar*, *anxiety* disorder, and *adjustment* disorder. The largest regional difference was adults diagnosed with *schizophrenia*. Wasatch Front centers (18.0%), mostly due to WS and VL, had a higher percent of persons diagnosed with schizophrenia than the NWF region (10.1%).

**Diagnosis (children and youth).** For CMHCs, diagnoses were most frequently assigned to the following specific disorder categories: *adjustment*, *attention deficit*, disorders associated with *abuse*, *oppositional defiance* and *major depression*. As expected, there was a contrast between CMHCs and the *Utah State Hospital* in diagnoses for *children and youth*. The following diagnoses assigned by the USH had higher percents than the CMHCs: *anxiety*, *schizophrenia*, *bipolar*, and *major depression*. On the other hand, *attention deficit* disorder was higher in CMHCs.

**Severity of mental illness.** Adults with *SPMI* were higher in the WF region (49.3%) than the NWF region (35.3%). Valley (56.4%) and NE (53.6%) had the largest proportions rated as

SPMI. Children and youth rated as SED were also higher in the WF region (45.7%) than the NWF region (36.4%). Valley, with 61.6 percent, was 12 percent higher than the next highest center.

On the assumption that CMHCs might be differently applying the SPMI measure, centers were compared using major mental illness (schizophrenia, bipolar, and major depression) as a criterion. In employing this criterion, it is recognized that certain aspects of severity such as duration and degree of dysfunction are missing. Nevertheless, one would expect a high correlation between these diagnoses and SPMI. These data *did* support the assumption of dissimilar use of the SPMI instrument by CMHCs.

Substantial incongruities between Major mental illness (MMI) percents and SPMI percents suggest that certain centers may be under-rating their SPMI populations. Major mental illness was higher by eight percent (8%) or higher in five of the 10 CMHCs (WS, CU, FC, SW and SJ). Of special note is that San Juan went from the lowest SPMI rating of 16.7 percent to 36.8 percent using the MMI rating. When SPMI and MMI percents are averaged for each center, WS (54.0%), VL (53.4%) and NE (51.4%) had the highest “adjusted” severity ratings. The remaining seven CMHCs ranged between 43.8 and 26.9 percent.

**Employment.** As with previous re-ports, the level of employment, a measure of client acuity, was relatively low for CMHC adult consumers. Less than one-fourth (23.9%) were employed full-time. When part-time is combined with full-time, slightly over one-third (36.2%) were employed in the competitive workforce. Employment was about five percent higher in the NWF area. DV had the largest proportion of consumers that were employed full-time (32.5%). If full and part-time employments are combined, DV was highest with 44 per-cent, followed closely by SW, BR and FC.

**Marital status.** The percent of adult clients reporting *never married* were higher in the WF region (38.3%) and the percent reporting *now married* were much higher in the NWF region (33.8%). About one-fourth of CMHC adults indicated being *divorced* and one-tenth reported being *separated*.

**Residential living arrangement.** *Private residence* at admission was the most frequent response for both CMHC adults (82.7%) and children/youth (85.0%). About one out of 25 adults and one out of a 100 children and youth reported being *homeless*. Wasatch, WB and VL had the largest proportions of homeless adults.

**Referral source.** Similar to past years, *self, family or friend* was the primary source of referral. WB had a very large proportion that was referred by the *courts, police, and corrections*. DV and VL also had substantial percents were referred by this source. WF CMHCs received these referrals more than NWF centers.

**Expected primary payment source (Medicaid/Non-Medicaid).** For CMHCs, the expectation by clients at the beginning of treatment that *children and youth* would receive *Medicaid* funding as their primary payment source was nearly double that for *adults* (58.1% vs. 31.4%). This is consistent with the more liberal Medicaid eligibility requirements for children and youth.

### **III. Statewide survey of adult clients**

This section focuses on CMHC client access to services, quality/appropriateness of treatment, outcomes and satisfaction, domains used by the Division since 1994. Data in each domain are found in the MHSIP Consumer Survey presented below. Research has validated a longitudinal and logical relationship between domains. As a client desires help from a CMHC the first concern is access, followed by quality and appropriate services. These services produce favorable *outcomes*. *Satisfaction* is the product of *access* and *quality/appropriate services*.

Adult clients were asked on a five-point rating scale consisting of “strongly agree, agree, neutral, disagree and strongly disagree,” how they felt about 28 statements. Results are presented in percents making comparisons between WF and NWF regions and CMHC totals.

#### **Access**

Statewide, 73 percent of responding clients were satisfied with the amount of time it took from their first contact with the CMHC until their first appointment, and 78 percent responded that services were at convenient times. Nearly eight percent more NWF than WF clients agreed that times were convenient. A higher proportion of NWF clients thought that the location of services was convenient. Overall for the state, 83 percent were in agreement.

Larger percents (8-11%) of NWF than WF clients reported being able to see a psychiatrist or other staff member when wanted. Statewide, 71 percent agreed with the statement about psychiatrists and 77 percent agreed with the statement about staff. On financial accessibility, 76 percent agreed the fee was fair and considered their needs.

*Responses on access received from clients in Non- Wasatch Front CMHCs were generally more favorable than responses from WF clients.*

#### **Quality/appropriateness**

Most (71%) agreed that staff returned phone calls within 24 hours and 71 percent, statewide, agreed they had been included in making decisions about their treatment. Statewide, 75 percent thought staff at their CMHC believe clients can grow, change, and recover. NWF centers (83%) were nearly 15 percent higher than WF centers. In the NWF region, 82 percent thought that staff were sensitive to cultural/ethnic background compared with 74 percent in the WF region and 77 percent overall.

Information and education are important in therapy. Statewide, 75 percent thought staff had helped them obtain information that could be helpful in illness management. NWF clients were eight percent higher in agreement on this statement. Only 60 percent of clients statewide perceived that staff had told them about medication side effects. *It is recommended that clinicians consider ways to enhance client awareness of medication side effects.* In the NWF region, 62 percent said that staff recommended self-help groups compared to WF's 52 percent.

Confidentiality is becoming a high- profile issue in health care. Higher proportions in the WF region (70%) than the NWF region (63%) believed staff respected client wishes about who was given information about treatment. Overall, 77 percent of clients reported they felt free to complain. Rural areas (80%) were higher than urban areas (75%) on this statement.

*NWF client satisfaction in quality/appropriateness was more favorable than WF clients in seven of 11 statements by margins ranging from 8-14 percent.*

## **Outcomes**

Outcomes are assessed by *measured* change and retrospective *perceptions of change*. The 10-item General Well-Being (GWB) symptom scale is an example of measured change. The GWB is completed by clients at admission to centers and again in 90 days. Change scores are computed and compared. Overall, 54 percent had significantly improved as measured on the GWB instrument.

Perceived outcome questions were prefaced by the phrase, “as a direct result of my treatment,” followed by the statement. When clients were asked about *symptoms* 90 days after admission, a similar question to the GWB, 58 percent responded that their symptoms were not bothering them as much. The NWF area (63%) was 7 percent higher on this statement. NWF clients (62%) thought they were better able to deal with crises compared to WF clients (55%).

On functioning, statewide, 55 per-cent of clients felt they were doing better at work and/or school. A higher percent of NWF (59%) than WF clients (7% less) felt they were doing better. Fifty-eight percent believed they could deal more effectively with daily problems. A higher proportion of NWF (65%) than WF clients (59%) thought they were better able to control their lives.

Comparing regions, NWF (64%) and WF (59%) clients believed they were getting along better with “my family.” NWF (62%) clients they were doing better in social situations. WF clients were 16 percent less on this statement. More NWF (56%) than WF clients (49%) believed their housing situation had improved.

NWF clients were more positive than urban in eight of nine statements, seven of which were six percent or more. *Studies have shown that satisfaction with outcome is 10-15 percent lower than in other domains.*

## **General satisfaction**

Overall, 83 per-cent of CMHC clients liked the services they received and 81 percent reported they would recommend the center to a friend or family member. Further, 73 percent indicated they would still get services at their CMHC even if they had other options. In rural areas, 91 percent thought that secretaries and receptionists had been helpful compared with 82 percent in the urban areas.